

## Alberta Aids to Daily Living (AADL) Wheelchair Replacement Request

Client Name (Last) (First)		Personal Health Number (PHN)	
Authorizer Number:		Authorization Number:	
Residence: <input type="checkbox"/> Home <input type="checkbox"/> Lodge <input type="checkbox"/> Group Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other:			
Diagnosis:			
<b>WHEELCHAIR CURRENTLY IN USE</b>			
Serial Number:		Make:	
Model:		How long has client had this wheelchair:	
<b>CURRENT PROBLEM</b>			
Who is complaining about the chair:		What is problem?	
Is this a problem for the client: <input type="checkbox"/> Yes <input type="checkbox"/> No How:			
How many hours a day does client use current w/c:		Environment changed:	
<b>PRIMARY ANTICIPATED OUTCOME (if request is approved)</b>			
State:			
<b>WHAT IS WRONG WITH CURRENT WHEELCHAIR</b>			
<b>DOESN'T FIT CLIENT</b>			
<input type="checkbox"/> Width <input type="checkbox"/> Depth <input type="checkbox"/> Seat to floor height		Can chair be grown/shrunk rather than replaced?	
AADL estimate to grow (AADL use this space \$_____)		Vendor says: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>DOESN'T SUPPORT CLIENT'S WEIGHT</b>			
Client changed weight: <input type="checkbox"/> Yes		Current weight:	Current weight stable for 3 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Drugs/disease affecting weight: <input type="checkbox"/> Yes <input type="checkbox"/> No		Short-term or long-term use of drugs:	
<b>CHAIR IN POOR CONDITION</b>			
What factors led to this poor condition:			
Checked by vendor: <input type="checkbox"/> Yes (work order attached)		Written off by AADL: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>PARTS CHANGE WITHIN 6 MONTHS OF RECEIVING CHAIR</b>			
What:		Why:	
<b>CHAIR TOO HEAVY FOR CLIENT TO PROPEL</b>			
Weight of current wheelchair:		Weight of requested wheelchair:	
Requested chair:			
<b>WHAT STEPS HAVE BEEN TAKEN TO MAKE THE CURRENT CHAIR WORK</b>			
Client wheeling ability examined: <input type="checkbox"/> Yes <input type="checkbox"/> No		Assist caregiver in handling chair properly: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home environment modifications needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is client willing to do modifications: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tried quick release axles: <input type="checkbox"/> Yes <input type="checkbox"/> No		Chair configuration adjusted by w/c dealer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>USE OF CUSHION</b>			
Does client use a cushion: <input type="checkbox"/> Yes <input type="checkbox"/> No		When did client receive the cushion:	
Make/Model:	Size:	Thickness:	Different cushion trialed: <input type="checkbox"/> Yes <input type="checkbox"/> No

**CHANGE IN CLIENT**

Document change in medical condition:

Document change in functional independence:

**CLIENT NEEDS TILT****CLIENT NEEDS RECLINE**

Why:

Why:

Pediatric – Tilt request is attached:  Yes  NoAdult – Aware of financial implications:  Yes  No**CURRENT USAGE**Does the client self propel:  Yes  NoIs client independent in current wheelchair:  Yes  NoUsing arms:  Yes  NoDoes the client go outside in wheelchair:  Yes  NoUsing feet:  Yes  No

How often \_\_\_\_\_ How far \_\_\_\_\_

Both:  Yes  No Alone, or  Accompanied**WHEELCHAIR REQUESTED**Is there a change in configuration of trial chair:  Yes  No If yes, what:Was it trialed in home:  Yes  No **If no, you must trial before sending in the request.**

Where trialed:

How long was trial:

**OUTCOME OF TRIAL** Increased independence Decreased potential for skin breakdown Increased comfort Increased distance for wheeling: How far \_\_\_\_\_ Less pain Sitting tolerance (able to sit longer): How long \_\_\_\_\_ Improved posture Easier for caregiver: How \_\_\_\_\_ Increased safety Easier transportation: Why \_\_\_\_\_ Decreased injury Other \_\_\_\_\_Spec. sheet attached:  Yes  NoHow will they **transport** this chair:**CAREGIVER ISSUES** Caregiver has been instructed in handling current wheelchair Caregiver has been shown how to release quick release axle Caregiver has health issues: What \_\_\_\_\_ Client is pushed in chair: By whom \_\_\_\_\_ Age \_\_\_\_\_ How often \_\_\_\_\_

Caregiver Impairments \_\_\_\_\_

**SEATING****Note: If this chair has seating installed, you must discuss this chair change with a Seating Clinic Team Member.**Does client need a referral to seating clinic:  Yes  NoHas client been seen in seating clinic:  Yes  NoDoes current wheelchair have **special seating** attached:  Yes  No If so, what:  Back  Laterals  Headrest

Will seating need to be:

At what cost:

Does this request require a change in seating:  Yes  NoChanged out:  Yes  NoModified:  Yes  No**(AADL use only – Seating appeal approved:  Yes  No)** See attached for more information (optional)

The personal information provided on this form is collected under the authority of the *Alberta Aids to Daily Living and Extended Health Benefits Regulation* and managed in accordance with the *Freedom of Information and Protection of Privacy Act*. The information will be used to determine entitlement to a wheelchair replacement. If you have any questions about the collection of this information, you can contact AADL, Disability Supports Division, Health Related Supports, 10<sup>th</sup> Floor, 10040 – 104 Street NW, Edmonton, AB T5J 0Z2. Telephone: 780-427-0731.

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